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Clinical Supervision in Speech-Language Pathology

Ad Hoc Committee on Supervision in Speech-Language Pathology

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About This Document

This technical report was developed by the Ad Hoc Committee on Supervision in Speech-Language Pathology of the American Speech-Language-Hearing Association (ASHA). Members of the committee were Lisa O'Connor (chair), Christine Baron, Thalia Coleman, Barbara Conrad, Wren Newman, Kathy Panther, and Janet E. Brown (ex officio). Brian B. Shulman, vice president for professional practices in speech-language pathology (2006–2008), served as the monitoring officer. This document was approved by the Board of Directors on March 12, 2008.

Introduction

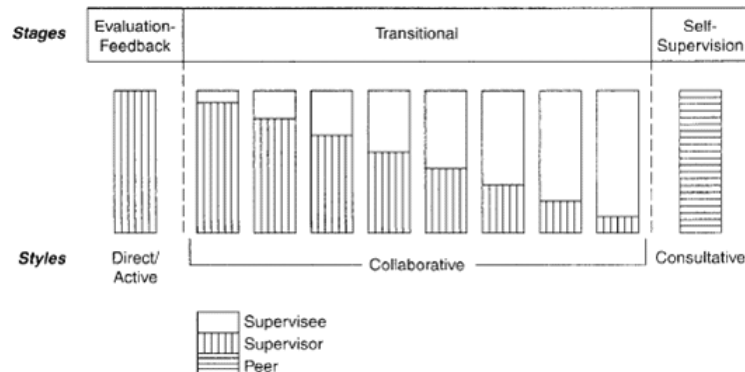
Because of increasing amounts of data from studies on supervision, advances in technology, and a greater understanding of the value of interpersonal factors in the supervisory process, there was a need to update ASHA's 1985 position statement *Clinical Supervision in Speech-Language Pathology and Audiology* (ASHA, 1985b). This 2008 technical report accompanies an updated position statement and knowledge and skills document for the profession of speech-language pathology (ASHA 2008a, 2008b). Although the principles of supervision (also called clinical teaching or clinical education) are common to both professions, the updated documents address only speech-language pathology because of differences in pre-service education and practice between the two professions.

The 1985 position statement identified specified competencies for supervisors, with an emphasis on clinical supervision of students. This 2008 technical report addresses supervision across the spectrum of supervisees, with the exception of speech-language pathology assistants. Professionals looking for guidance in supervising support personnel should refer to the ASHA position statement, guidelines, and knowledge and skills documents on this topic (ASHA, 2002, 2004b, 2004e).

As stated in ASHA's position statement on clinical supervision in speech-language pathology (ASHA, 2008a), “clinical supervision (also called clinical teaching or clinical education) is a distinct area of practice in speech-language pathology and ... is an essential component in the education of students and the continual professional growth of speech-language pathologists” (p. 1). Clinical supervision is also a collaborative process, with shared responsibility for many of the activities throughout the supervisory experience.

At some point in their career, many speech-language pathologists (SLPs) will be involved in a role that involves supervising students, clinical fellows, practicing SLPs, and/or paraprofessionals. Many of these SLPs do not have formal training or preparation in supervision. Recognizing the importance and complexity involved in the supervisory process, it is critical that increased focus be devoted to knowledge of the issues and skills in providing clinical supervision across the spectrum of a professional career in speech-language pathology. The purpose of this technical report is to highlight key principles and issues that reflect the importance and the highly skilled nature of providing exemplary supervision. It is not intended to provide a comprehensive text on how to become a supervisor. The companion document *Knowledge and Skills Needed by Speech-Language*

Figure 1. Continuum of supervision. From *The Supervisory Process in Speech-Language Pathology and Audiology* (p. 25), by E. S. McCrea and J. A. Brasseur, 2003, Boston: Allyn and Bacon. Copyright © 2003 by Pearson Education. Reprinted by permission of the publisher.



Background Information

Pathologists Providing Clinical Supervision (ASHA, 2008b) delineates areas of competence, and the position statement *Clinical Supervision in Speech-Language Pathology* (ASHA, 2008a) affirms the role of supervision within the profession.

In 1978, the ASHA Committee on Supervision indicated that there was little knowledge of the critical factors in supervision methodology (American Speech and Hearing Association, 1978). During the three decades since that report was written, a body of work has been published that has helped to identify some of the critical factors in supervision methodology and their relationship to the effectiveness of supervision.

Jean Anderson's *The Supervisory Process in Speech-Language Pathology and Audiology* (1988) played a significant role in helping professionals understand the critical factors in supervision methodology and their contribution to the effectiveness of supervision. Her continuum of supervision is the most widely recognized supervision model in speech-language pathology (see Figure 1). This model is based on a developmental continuum that spans a professional career.

The continuum mandates a change over time in the amount and type of involvement of both the supervisor and the supervisee in the supervisory process. As the amount of direction by the supervisor decreases, the amount of participation by the supervisee increases across the continuum (J. L. Anderson, 1988). The stages (evaluation-feedback, transitional, self-supervision) should not be viewed as time-bound, as any individual supervisee may be found at any point on the continuum depending on situational variables as well as the knowledge and skill of the supervisee. The model stresses the importance of modifying the supervisor's style in response to the needs, knowledge, and skills of the supervisee at each stage of clinical development. This model also fosters professional growth on the part of both the supervisor and the supervisee.

Research on Supervision

In addition to the publications from acknowledged experts in the profession, ASHA has provided guidance in the area of supervision through standards, the Code of Ethics, and Issues in Ethics statements. These documents are described below in the sections *Standards*, *Regulations*, and *Legal Issues and Ethical Considerations in Supervision*.

As the profession of speech-language pathology has advanced, evidence-based knowledge about practice in clinical disorders has developed through experimental and descriptive research. However, there is little empirical evidence in the area of supervision (Spence, Wilson, Kavanagh, Strong, & Worrall, 2001), especially as it relates to client outcomes. Knowledge about supervision in speech-language pathology has primarily come from descriptive studies documented in texts by acknowledged experts, conference proceedings, and personal and shared experience. The results of descriptive studies have led to the identification of some of the behaviors that supervisors need to modify in order to be less directive and to facilitate high levels of critical thinking in supervisees (Dowling, 1995; Strike-Roussos, 1988, 1995, as cited in McCrea and Brasseur, 2003). Another major source of information about supervision comes from the research literature from other professions. McCrea and Brasseur (2003) examined the work of Rogers (1951), Carkhuff (1967, 1969), Leddick and Barnard (1980), and Hart (1982) in psychology; Fiedler (1967) in business management; Kagan (1970) in social work; and Cogan (1973) and Goldhammer (1969; Goldhammer, Anderson, & Kajewski, 1980) in education to show the extent to which other disciplines have contributed to our knowledge of effective supervision, and to emphasize the shared core principles of supervision regardless of the discipline and/or service delivery setting (Dowling, 2001).

Definition of Supervision

In 1988 Jean Anderson offered the following definition of the supervisory process:

Supervision is a process that consists of a variety of patterns of behavior, the appropriateness of which depends on the needs, competencies, expectations and philosophies of the supervisor and the supervisee and the specifics of the situation (tasks, client, setting and other variables). The goals of the supervisory process are the professional growth and development of the supervisee and the supervisor, which it is assumed will result ultimately in optimal service to clients. (p. 12)

Anderson's definition is still consistent with the goals of the process but needs some expansion. ASHA's position statement (1985b) noted that "effective clinical teaching" involves the development of self-analysis, self-evaluation, and problem-solving skills on the part of the individual being supervised. Self-analysis and self-evaluation are important activities for the supervisor as well. Therefore, Anderson's definition may be expanded to include the following:

Professional growth and development of the supervisee and the supervisor are enhanced when supervision or clinical teaching involves self-analysis and self-evaluation. Effective clinical teaching also promotes the use of critical thinking and problem-solving skills on the part of the individual being supervised.

Supervision Across Settings

Critical thinking is based on building hypotheses, collecting data, and analyzing outcomes. A supervisor can facilitate the critical thinking abilities of supervisees through collecting data and facilitating problem solving. Engaging in this process will also help supervisees assess the quality of their service delivery. The *Data Collection in Supervision* section that follows provides further information on this topic.

The following sections discuss key issues that affect supervision or influence the supervisory process.

Professional, clinical, and operational demands across practice settings vary; however, the supervisory process can be viewed as basically the same wherever speech-language pathology services are delivered. Client populations as well as equipment, tools, and techniques used to provide clinical services can differ across the practice settings. Nevertheless, the dynamics of the supervisory relationship and the components of the supervisory process are similar regardless of work setting.

Often the supervisor is also responsible for day-to-day operations and program management. These supervisors with management responsibilities are accountable to multiple stakeholders (e.g., administrators, regulatory agencies, consumers, employees, and payers). These supervisors also have an obligation to provide clinical teaching to supervisees at all levels of their career. Clinical education may be managed directly by the supervisor, facilitated as a collaborative activity by the supervisor, or delivered in peer training formats (e.g., through literature review and discussion, or continuing education). Methods may vary according to the needs of the clinical population, developmental level of the supervisee, supervisor and supervisee teaching/learning styles and preferences, economics, and practice setting. The basic objective of professional growth and development for both the supervisor and supervisee remains at the core of the supervisory process.

Technology in Supervision

Although technology is not a new concept in supervision, the ways in which technology may be used have changed immensely. It can allow one message to be received by many at one time (through an e-mail list) or it can provide support to just one supervisee through the use of two-way videoconferencing (i.e., “e-supervision”). Through the use of technology, information can be delivered at a distance in real time or be archived for users to retrieve at their convenience. Many forms of technology can be used to support communication and clinical teaching, particularly the Internet, which facilitates the use of e-mail, e-mail lists, instant messaging, Web sites/pages, videoconferencing, video software, Weblogs (or “blogs”), and podcasting. The Appendix provides examples of current uses of technology for supervision. When one uses technology in supervision (e.g., videoconferencing) it is important to be aware of and follow regulatory guidelines involving confidentiality.

The Influence of Power in Supervision

Power has been defined as the ability of one party to change or control the behavior, attitudes, opinions, objectives, needs, and values of another party (Rahim, 1989). Although different models and descriptions of power are described in the literature, some researchers have acknowledged the importance of modifying supervisees' behavior using social and interpersonal influence processes. One form of social

Mentoring in Supervision

influence is power (Wagner & Hess, 1999). According to Robyak, Goodyear, and Prange (1987), supervisors' power influences trainees to change their clinical behaviors. Other disciplines have extensively investigated social power because of the influence that power has on subordinates' compliance, motivation, satisfaction, task commitment, job performance, and interpersonal conflicts (Wagner & Hess, 1999).

Understanding the influence of social power on the supervisory relationship is important. Supervisors hold the power of grading, signing off on clinical hours, conducting performance evaluations, and making promotion decisions. Lack of awareness of the influence of power can result in intimidation and a reluctance on the part of the supervisee to participate actively in the supervisory experience.

Individuals from diverse cultural and/or linguistic backgrounds may respond differently to the power dynamic (e.g., to people they perceive to be in roles of authority). They may behave in ways that may be interpreted as inappropriate by those who are unfamiliar with their culture and/or background (Coleman, 2000). Therefore, it is important for supervisors to know when to consult someone who can serve as a cultural mediator or advisor concerning effective strategies for culturally appropriate interactions with individuals (clients and supervisees) from specific backgrounds.

The terms *mentoring* and *supervision* are not synonymous but are often used interchangeably (Urish, 2004). Mentoring is typically defined as a relationship between two people in which one person (the mentor) is dedicated to the personal and professional growth of the other (the mentee) (Robertson, 1992). While this definition may sound similar to the relationship of the supervisor and the supervisee, the primary focus of supervision is accountability for the supervisee's performance (e.g., providing grades or conducting performance evaluations; documenting professional behavior and clinical performance). In contrast, mentoring focuses on creating effective ways to build skills, influence attitudes, and cultivate aspirations. Mentors advise, tutor, sponsor, and instill a professional identity in mentees. Mentoring is an intense interaction between two people, where the mentor has authority and power based on experience. To highlight the importance of the mentoring role, the 2005 ASHA Standards for Clinical Certification references mentoring. In some sections the terminology has been changed from *supervision* to *mentoring* and from *clinical fellowship supervisor* to *clinical fellowship mentor* (Council for Clinical Certification in Audiology and Speech-Language Pathology [CFCC], 2005).

Some aspect of mentoring should be involved in all supervisory relationships, the degree being dependent on supervisory style, the amount of experience and skill level of the supervisee, and factors associated with the practice setting. Supervisors who maintain a "direct-active" style of supervision as described by J. L. Anderson (1988) are less likely to address the mentoring aspect of supervision. The "direct-active" style focuses mainly on growth in performance rather than on the personal growth of the supervisee. "Collaborative" or "consultative" styles, as described by J. L. Anderson (1988), better facilitate the ability to address the mentoring aspect of supervision. Mentoring is most appropriate when supervisees have moved into the advanced level of the "transitional stage" and/or the self-supervision stage on the Anderson continuum.

Training in Supervision

Many professionals are thrust into the role of supervisor or clinical educator without adequate preparation or training (J. L. Anderson, 1988; Dowling, 2001; McCrea & Brasseur, 2003; Spence et al., 2001). They become “overnight supervisors” and are forced to draw on their own past experiences as supervisees, positive or negative, as a source for their own techniques and methodologies. Supervisors in all practice settings may also have unrealistic expectations concerning the academic and clinical preparation of supervisees, particularly students.

Dowling (2001) and McCrea and Brasseur (2003) discussed research in speech-language pathology by Culatta and Seltzer (1976), Irwin (1975, 1976), McCrea (1980), Roberts and Smith (1982), and Strike-Roussos (1988, 1995) indicating that supervisors who engage in supervisory conferences/meetings without formal supervisory training tend to dominate talk time, problem solving, and strategy development. These supervisors tend to use the same direct style of supervision with all supervisees regardless of their knowledge or skill levels, and without regard for the supervisee's learning style, which can lead to passive supervisee involvement and dependence on the supervisor (J. L. Anderson, 1988). Further, a direct style of supervision diminishes the need for the supervisee to use critical thinking and problem-solving skills. Supervisors should seek training on the supervisory process so that they can learn about differing supervisory styles and develop competence in supervision. This will help ensure the use of strategies and behaviors that promote supervisee learning and development. ASHA's *Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision* (ASHA, 2008b) lists competencies for effective supervision. Training in supervision can be obtained through course work, continuing education programs, self-study, peer mentoring, and resources from ASHA (e.g., products and/or continuing education offerings) and from Special Interest Division 11, Administration and Supervision.

Supervisor Accountability

Quite often, the effectiveness of a supervisor is determined by asking the supervisee to evaluate the clinical instructor. While such evaluations do have some importance, few supervisees have sufficient understanding of the supervisory process to know what to expect of a supervisor. Further, unless complete anonymity is ensured, the likelihood of receiving honest feedback may be questioned. Therefore, supervisors should also evaluate their own behaviors relative to the supervisory process. Given the lack of validated guidelines for accomplishing such self-evaluation, supervisors must devise their own methods of data collection (McCrea & Brasseur, 2003) or turn to resources from other fields. Casey (1985) and colleagues (Casey, Smith, & Ulrich, 1988) developed a self-assessment guide to assist supervisors in determining their effectiveness in acquiring the 13 tasks and 81 associated competencies contained in the 1985 position statement (ASHA, 1985b). Analyzing the results allows the supervisor to identify supervisory objectives, decide on certain procedures, and determine whether goals were accomplished.

Studying the supervisory process in relation to one's own behavior is an opportunity for the supervisor to develop a personalized quality assurance mechanism, and a way to ensure accountability. Making a decision to improve as a supervisor also promotes job satisfaction, self-fulfillment, and ethical behavior, and prevents burnout (Dowling, 2001).

Data Collection in Supervision

Objective data about the supervisee's performance adds credibility and facilitates the supervisory process (J. L. Anderson, 1988; Shapiro, 1994). According to J. L. Anderson (1988) and Shapiro (1994), data collection methods can include rating scales, tallying behaviors, verbatim recording, interaction analysis, and individually designed methods. A number of tools have also been developed for analysis of behaviors and self-assessment (J. L. Anderson, 1988; Casey et al., 1988; Dowling, 2001; McCrea & Brasseur, 2003; Shapiro, 1994). Results from the analysis of this data can be applied both to the supervisee's clinical interactions with clients as well as to behaviors of the supervisor and supervisee during supervisory conferences. Analysis of both the supervisee and supervisor's behaviors during supervisory conferences can yield valuable insights to improve the interactions and outcomes of the supervisory experience for both individuals.

To be effective at their job, supervisors must be concerned about their own learning and development. Studying one's own behavior in supervisory process not only facilitates accountability in clinical teaching, but also is an opportunity for supervisors to examine their own behavior in order to improve their effectiveness in supervision.

Communication Skills in Supervision

Although supervisors may collect data and analyze the behaviors of supervisees, success in facilitating a supervisee's development may ultimately rest on the supervisor's skill in communicating effectively about these behaviors. While there are many resources that discuss interpersonal communication, McCrea and Brasseur (2003) briefly reviewed the literature in speech-language pathology on the interpersonal aspects of the supervisory process, citing Pickering (1979, 1984, 1987, 1990), Caracciolo and colleagues (1978), Crago (1987), Hagler, Casey, and DesRochers (1989), McCrea (1980), McCready and colleagues (1987, 1996), and Ghitter (1987). All of these researchers found a relationship between the interpersonal skills of supervisors and the clinical effectiveness of the supervisees. In their review of the literature, McCrea and Brasseur noted the importance of a supervisor's skill in communication. Adopting an effective communication style for each supervisee was shown to affect the supervisees' willingness to participate in conferences, share ideas and feelings, and positively change clinical behaviors. Ghitter (1987, as cited in McCrea & Brasseur, 2003) reported that when supervisees perceive high levels of unconditional positive regard, genuineness, empathic understanding, and concreteness, their clinical behaviors change in positive directions.

The ability to communicate effectively is viewed by many as an aptitude or an innate skill that people possess without any training. However, many professionals operate at a level of effectiveness far below their potential (Adler, Rosenfeld, & Proctor, 2001). There are also potential barriers to clear and accurate communication (e.g., age, gender, social and economic status, and cultural/

linguistic background). Further information addressing such barriers is included in the sections *Generational Differences* and *Cultural and Linguistic Considerations in Supervision*). Training in interpersonal communication is an important component of supervisory training. Growth in the interpersonal domain will enhance supervisors' proficiencies in interacting with clinicians in a helpful manner.

Standards, Regulations, and Legal Issues

Various external groups provide guidance for or regulation of supervision in speech-language pathology, particularly with respect to students and clinical fellows. ASHA's standards for certification and accreditation, state licensure laws, and federal/state reimbursement programs set minimum standards for the amount of supervision provided to individuals who are not certified SLPs.

At the preprofessional level, the *Standards for Accreditation of Graduate Education Programs in Audiology and Speech-Language Pathology* (Council on Academic Accreditation in Audiology and Speech-Language Pathology [CAA], 2004) require competent and ethical conduct of faculty, including on-site and off-site faculty. The standards also require programs to demonstrate that "Clinical supervision is commensurate with the clinical knowledge and skills of each student..." (Standard 3.5B; CAA, 2004).

Standards and Implementation Procedures for the Certificate of Clinical Competence address the requirements for direct and indirect supervision of students (CFCC, 2005). The standards require that student supervision be provided by a certified SLP, and that at least 25% of a student's total contact with each client be directly observed. The amount of supervision "should be adjusted upward if the student's level of knowledge, experience, and competence warrants" (CFCC, 2005). Standards for clinical fellows require 36 mentoring activities, including 18 hours of on-site direct client contact observation. Both sets of standards may be updated periodically.

Regulation by state licensure boards is separate from ASHA requirements; therefore, all students, clinical fellows, and certified clinical practitioners must be aware of and adhere to ASHA certification requirements as well as their state's requirements. Licensure laws regulate the provision of SLP services within the state; for SLPs practicing in schools, different or additional standards may also be required. States' requirements for student supervision may in some cases exceed ASHA's requirements.

Supervisors also must be aware of regulations for student supervision issued by payers such as the Centers for Medicare and Medicaid Services (CMS). For services delivered to Medicare beneficiaries under Part B, Medicare guidance explicitly states that the qualified SLP must be in the room at all times and be actively engaged in directing the treatment provided by the student (CMS, 2003, chapter 15, section 230B.1). There is an exception for services to Part A beneficiaries residing in a skilled nursing facility where "line of sight" supervision of the student by the qualified SLP is required instead of "in the room."

The nature of the supervisory relationship includes a vicarious liability for the actions of the supervisee. Supervisors hold full responsibility for the behavior, clinical services, and documentation of the student clinician. For their own protection as well as to foster the growth of students and protect the welfare of clients, supervisors must be fully involved and aware of the performance of the student and address any issues that could affect patient outcomes or satisfaction.

Ethical Considerations in Supervision

ASHA's Code of Ethics (2003) provides a framework for ethical behavior of supervisors across supervisory responsibilities. Principle of Ethics I states that client welfare must always be held paramount. Accordingly, the supervisor must provide appropriate supervision and adjust the amount and type of supervision based on the supervisee's performance. The supervisor ensures that the supervisee fulfills professional responsibilities such as maintaining confidentiality of client information, documenting client records in an accurate and timely manner, and completing other professional activities. In addition, the supervisor has an obligation to inform the client of the name and credentials of individuals (such as students) involved in their treatment.

Principle of Ethics II addresses issues of professional competence, and its rules state that professionals should only engage in those aspects of the profession that are within their scope of competence. Accordingly, supervisors should seek training in the area of effective supervisory practices to develop their competence in this area. Supervisors also have the responsibility to ensure that client services are provided competently by supervisees whether they are students, clinical fellows, or practicing clinicians. In addition, the rules state that treatment delegated to clinical fellows, students, and other nonprofessionals must be supervised by a certified speech-language pathologist.

Principle of Ethics IV addresses the ethical responsibility to maintain “harmonious interprofessional and intraprofessional relationships” and not abuse their authority over students (ASHA, 2003). See the section *The Influence of Power in Supervision* for further discussion of this issue.

Issues in Ethics statements are developed by ASHA's Board of Ethics to provide guidance on specific issues of ethical conduct. Statements related to supervision include *Fees for Clinical Service Provided by Students and Clinical Fellows* (ASHA, 2004a), *Supervision of Student Clinicians* (ASHA, 2004d), and *Responsibilities of Individuals Who Mentor Clinical Fellows* (2007).

Supervisors should also be cognizant of the problems that may arise from developing a social relationship with a supervisee in addition to their supervisory relationship. Although working together may provide opportunities for socialization beyond professional activities, supervisors must be comfortable in addressing a supervisee's performance without being influenced by their relationship outside the work setting.

King (2003) identified situations where ethical misconduct in the area of supervision may occur. Although King's comments were directed to the supervision of students, these concerns can be applied to all supervisory relationships. According to King, situations of potential misconduct can include,

but are not limited to, failure to provide a sufficient amount of supervision based on the performance of the supervisee, failure to educate and monitor the supervisee's protection of patient confidentiality, failure to verify appropriate competencies before delegating tasks to supervisees, failure to demonstrate benefit to the patient based on outcomes, and failure to provide self-assessment tools and opportunities to supervisees.

Supervision by Other Professionals

Increasingly, ASHA-certified SLPs and clinical fellows may work in settings where their direct supervisor may be an administrator or an individual from another profession. Evaluation of clinical skills by that individual is not appropriate, according to ASHA's position statement on *Professional Performance Appraisal by Individuals Outside the Professions of Speech-Language Pathology and Audiology* (ASHA, 1993). Peer appraisal and/or self-evaluation are recommended as alternatives. In addition, guidelines on the *Professional Performance Review Process for the School-Based Speech-Language Pathologist* (ASHA, 2006) were recently developed to help address this frequently occurring situation in schools.

Access to Clinical Externships

Practicing SLPs participate in the training and development of those who are entering the profession. However, pressures within the workplace have created challenges to students gaining access to externship sites (McAllister, 2005). Students are considered by some clinicians and administrators to be a drain on existing resources. The pace of the work, productivity demands, complexity of clients, and program specialization can limit an organization's willingness to embrace the task of student training (McAllister, 2005). In some cases, an externship supervisor's expectations of a student's knowledge and skills may be unrealistic and/or not met. Requirements for specified levels of supervision imposed by regulatory agencies (e.g., CMS) have also been identified as barriers to accepting students.

Staffing shortages can also limit student placement opportunities. Student training is often one of the casualties of inadequate staffing in the workplace. Veteran SLPs have much to offer students and other supervisees, but these individuals may work on a part-time or as-needed basis. Organizations that implement flexible work schedules to retain seasoned employees may refuse student placements because they believe they cannot accommodate the students' scheduling needs (McAllister, 2005). An unfortunate irony exists because sites that do not offer student externship placements are less likely to successfully recruit qualified SLPs.

McAllister (2005) posited the need for innovative solutions in the following areas. A shift in training models may be necessary in some cases to provide more opportunities for student placements. Ingenuity and collaboration between universities and work sites can ultimately produce innovative scheduling, supervisory incentives, and exploration of new supervisory models that may allow for excellent training opportunities. Cooperative partnerships between the universities, work sites, and clinicians are needed to develop collaborative training models appropriate to work site demands and pressures. Universities can play a key role in assisting work sites in experimenting with and evaluating innovative training models and in educating potential and existing supervisors on best practices in clinical education.

Cultural and Linguistic Considerations in Supervision

The population of the United States is becoming increasingly diverse. Supervisors will interact more frequently with individuals from backgrounds that are different from their own. As they interact with others, supervisors will have to take into account culturally based behaviors, values, and belief systems to be successful in their interactions. No universal communication, learning, or behavioral style is used by all people. Many cultural values have a significant impact on how and when individuals choose to communicate, how they behave in various settings, and how they prefer to learn. Differences in cultural values have an impact on the nature and effectiveness of all aspects of clinical interactions, including supervisor-supervisee relationships. Supervisors must take into consideration culturally based behaviors and learning styles of supervisees if their interactions with them are to be successful (Coleman, 2000).

Shapiro, Ogletree, and Brotherton (2002) reported research findings that most faculty were viewed as not being prepared for engaging in the supervisory process even with students from mainstream backgrounds. This problem is even more widespread in view of previous findings that most SLPs do not believe they are prepared to work effectively with clients from culturally and linguistically diverse backgrounds (ASHA, 1985a; Carey, 1992; Coleman & Lieberman, 1995; Keough, 1990). The lack of understanding and/or appreciation for culturally and linguistically diverse clients could also have a significant impact on the nature of interactions these professionals have with other nontraditional students, such as older students or returning students (McAllister, 2005).

Supervisors who supervise individuals from culturally and linguistically diverse backgrounds should develop competencies that will help them engage in appropriate clinical education practices (ASHA, 1998a, 1998b, 2004c, 2005). Many researchers across disciplines have addressed the issue of culturally appropriate clinical intervention strategies (Adler, 1993; N. B. Anderson, 1992, Battle, 1993, Cheng, 1987, Langdon & Cheng, 1992). One of the first suggestions in most of these sources is that the service provider conduct a self-inventory of his or her cultural awareness and sensitivity. Resources for cultural competence awareness assessment may be obtained through ASHA and/or literature review. Recognizing that behavior may be influenced by culture allows supervisors to develop a better understanding of variations among people.

Generational Differences

The coexistence of multiple generations in the workforce presents unique challenges in supervision. Differences in values and expectations of one generation versus another can result in misinterpretations and misunderstandings during supervisor-supervisee interactions. McCready (2007) noted that various authors (Kersten, 2002; Lancaster & Stillman, 2002; and Raines, 2002, 2003) have mentioned that the disparities among generations today are deeper and more complex than in the past. According to Lancaster and Stillman (2002), there are four separate and distinct generations working together today: the Traditionalists (born between 1900 and 1945), the Baby Boomers (born 1946–1964), the Generation Xers (born 1965–1980), and the Millennials (1981–1999). People, places, events, and symbols not only define each of these generational cohorts but

profoundly influence their values and expectations. Supervisors therefore need to be prepared to understand and accommodate attitudes and behaviors that may differ from their own.

McCready (2007) described ways in which supervisors across work settings can bridge the generation gap and facilitate improved communication. One suggestion is to form study groups to investigate the research in this area; the group could then present their findings to a larger group within the work setting (McCready, 2007). The supervisor can also engage in discussions about the generations represented in the work setting and how generational characteristics may and may not apply to specific individuals (McCready, 2007). Such discussion might include generational characteristics that can lead to miscommunication and misunderstandings in interactions with clients and supervisors.

Supervising Challenging Supervisees

Students who are admitted to graduate programs in communication sciences and disorders have successfully passed through a very competitive screening process using a variety of selection criteria such as Graduate Record Examination scores, undergraduate grade point averages, and letters of recommendation. Most of these students perform well in their academic courses and clinical assignments.

However, most training programs periodically encounter students who present special challenges during the supervisory process (Shapiro et al., 2002) and are often referred to as “marginal” students. Dowling (1985, as cited in Dowling, 2001) described marginal students as individuals who “cannot work independently, are unable to formulate goals and procedures, have basic gaps in conceptual understanding, and cannot follow through with suggestions” (p. 162). Given the impact on students, programs, clients, and the professions, working effectively with marginal students deserves serious and systematic consideration (Shapiro et al., 2002). These same issues may apply to supervisees of varying experience levels and in all practice settings.

One characteristic that is frequently reported about these challenging supervisees is their lack of ability to accurately evaluate their skill level (Kruger & Dunning, 1999, as cited in McCrea & Brasseur, 2003). Using the supervisory conference/meeting can be critically important in assisting them in evaluating their own performance (Dowling, 2001). During these meetings, supervisors need to give specific feedback based on data collected about the supervisee's performance and provide concrete assistance in planning and strategy development (Dowling, 2001). Eventually, however, the supervisee must learn to engage in self-analysis and self-evaluation to develop an understanding of his or her own performance.

Summary

This document defines supervision and highlights key issues that reflect the complexity of providing exemplary supervision. Acquiring competency as a supervisor is essential to developing supervisory behaviors and activities that are critical to the training of professionals. Such supervisory training may not be provided as part of graduate education programs; therefore, SLPs must look to continuing education opportunities, peer learning and mentoring, and self-study using literature that focuses on the supervisory process (J. L. Anderson, 1988; Casey et al., 1988; Dowling, 2001; McCrea & Brasseur, 2003; Shapiro, 1994; Shapiro & Anderson, 1989). Although there may be opportunities to learn from other disciplines that also use supervisory practices, preparation in the supervisory

Research Directions

process specific to speech-language pathology is critically important. McCrea and Brasseur (2003) and Dowling (2001) discussed ways in which preparation in the supervisory process can be implemented. The models discussed in these texts range from inclusion of information in early clinical management courses to doctoral level preparation. Training that is included as part of academic and clinical training of professionals and extended to supervisors at off-campus practicum sites will enhance the supervisors' effectiveness (Dowling, 1992; and Dowling, 1993, 1994, as cited in McCrea & Brasseur, 2003). ASHA's *Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision* (ASHA, 2008b) delineates specific areas of competence deemed necessary to the provision of effective supervision.

Systematic study and investigation of the supervisory process is necessary to expand the evidence base from which increased knowledge about supervision and the supervisory process will emerge. Topics for further research may include the following:

- exploring different supervisory approaches that promote problem solving, self-analysis, and self-evaluation to develop clinical effectiveness;
- identifying essential components of training effective supervisors;
- examining the efficacy of supervisory training on supervisor/supervisee satisfaction and competence;
- identifying the basic behaviors/skills that supervisors should use in their interactions with supervisees that are essential to an effective working relationship;
- examining how supervisory style affects the development of clinical competence;
- examining different methods to develop more efficient models of supervision;
- examining supervisor behaviors that enhance supervisee growth (e.g., examining the process for negotiating and mutually agreeing on targets for change and measuring the impact that supervisor change has on the supervisee's professional growth) or training supervisors to use specific interpersonal skills (e.g., empathy, active listening) and then measuring how such skills enhance supervisee growth (McCrea & Brasseur, 2003);
- examining the effectiveness and efficiency of technology in delivering supervision;
- examining the impact of supervision on client outcomes;
- examining supervisory approaches and communication styles with supervisees in consideration of gender, age, cultural, and linguistic diversity;
- examining aspects of the supervisory process (i.e., understanding, planning, observing, analyzing, and integrating) and the relationship of each to the success of the supervisory experience (McCrea & Brasseur, 2003).

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Appendix

Uses of Current Technology for Supervision

E-mail with attachments: The primary benefit of using electronic mail is the speed of delivery versus traditional mail. If contacting the supervisor by phone is difficult, an e-mail message may be sent instead. With e-mail, the supervisor has the option of responding at his or her convenience rather than trying to schedule a phone call or a face-to-face meeting with the supervisee when only a short response may be required. Lesson plans, sample individualized education program goals, diagnostic reports, and so on may be attached and submitted to the supervisor for his or her review and comment.

E-mail lists: Sending messages via e-mail to a closed list of supervisees. Each supervisee has the opportunity to ask questions, pose problems, or ask for suggested resources from peers. This can be extremely powerful in learning from each other's experiences and sharing innovative ideas or tried-and-true therapy techniques.

Instant messaging: The individual can see which other individuals are available at their computer through "buddy" icons and contact them through instant messaging. A group can communicate in an instant messaging conference, or the SLP can converse with his or her supervisor instantly rather than waiting for the supervisor to check e-mail.

Web sites/Web pages: Information pertinent to supervisees (such as frequently asked questions on licensure renewal, guidelines on service delivery options, or frequently used forms) is placed on the supervisor's Web site. The supervisees can access the information when needed. Supervisees can suggest what materials, links, or resources they would find helpful to have uploaded to the supervisor's site.

E-supervision: Using two-way videoconferencing to supervise graduate students in a public school setting is one example of electronic supervision according to Dudding and Justice (2004). The equipment costs of videoconferencing are offset by the productivity in clinical instruction. Dudding and Justice reported that electronic supervision allows for more flexibility in scheduling and a reduction in travel costs while also increasing the student's knowledge and appreciation for technology.

Video software: Embedding a visual message within an e-mail or on a Web site provides access to information when it is needed, and the message can be archived for later reference as well. With the use of video software, the supervisor can easily video record a message while also embedding photos or graphics into the message. The software requires a simple mounted camera on the computer to video record the supervisor's message. The message can be an update on therapy techniques or a short training on the use of new forms, for example. Once recorded, it can be embedded into an e-mail and sent out to all of the supervisees or archived on a Web site to be accessed when needed. This expedites the training process by only recording and delivering the message one time and makes the information available when the supervisee has time to retrieve the information, which can differ for all involved.

Weblogs: Journal entries displayed in reverse chronological order. The supervisor and others can leave comments or statements of support for the supervisee in this interactive format.